The International Maritime Rescue Federation Mass Rescue Operations Project:

*General guidance on supporting survivors during rescue*

**Overview**

The IMRF’s mass rescue operations (MRO) guidance is provided in 30 separate chapters at [www.international-maritime-rescue.org](http://www.international-maritime-rescue.org). For downloadable documents referenced in this chapter please use the drop-down menus or return to the MRO project main page under ‘Resources’. For a general introduction please see chapter 1, ‘Complex incident planning – the challenge: acknowledging the problem, and mass rescue incident types’.

This chapter discusses:

- the ‘temporary place of safety’ in the mass rescue context: the transfer phase
- survivor safety, shelter and welfare support
- medical triage and first aid
- the provision of information to, and the collection of information from, survivors in transit

1 **Rescue**

1.1 The IMO define ‘rescue’ as the “operation to retrieve persons in distress, provide for their initial medical or other needs and deliver them to a place of safety”. As noted in chapter 8, it is useful to consider this in three parts – ‘retrieval’, providing for survivors’ initial needs, and delivery to a ‘place of safety’.

1.2 This chapter considers how best to support people during the transfer phase – *after* they have been removed from “grave and imminent danger”\(^1\) but *before* they reach the ‘final’ place of safety, usually ashore. For discussion of the retrieval of people in distress see chapter 8. For discussion of ‘final’ places of safety see chapter 11.

1.3 This chapter also considers the information that rescuers should gather about, and from, the people they have retrieved.

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\(^1\) The IAMSAR Manual defines distress (‘the distress phase’) as “a situation wherein there is reasonable certainty that a vessel or other craft, including an aircraft or a person, is threatened by grave and imminent danger and requires immediate assistance”. 
2 A temporary ‘place of safety’

2.1 A ‘place of safety’ is defined in IAMSAR as “a location where rescue operations are considered to terminate; where the survivors’ safety of life is no longer threatened and where their basic human needs (such as food, shelter and medical needs) can be met; and, a place from which transportation arrangements can be made for the survivors’ next or final destination. A place of safety may be on land, or it may be on board a rescue unit or other suitable vessel or facility at sea that can serve as a place of safety until the survivors are disembarked at their next destination.”

2.2 Getting survivors to places of safety is the aim of rescue, and hence of mass rescue operations. The place of safety is, by definition, the end of the rescue phase. We discuss this further in chapter 11. But the IMO definition of a place of safety allows for the concept of a ‘temporary’ place of safety at sea “until the survivors are disembarked at their next destination”. It is useful to plan to provide people with the same support during this transfer, as nearly as possible, as they will require at the end of the rescue phase.

2.3 The primary aims during the transfer phase should therefore be to ensure that:

- survivors' safety of life is no longer threatened
- they are sheltered from the elements
- they can be given food and drink
- their medical needs can be met.

2.4 The list of ‘basic human needs’ in the IMO definition of a place of safety is not exhaustive. As regards the ‘final’ place of safety, we suggest more headings in chapter 11. We also suggest that the following should be added, if possible, to the list of needs to be considered while survivors are in the ‘temporary’ place of safety:

- basic sanitary facilities
- information provision
- communications facilities.

2.5 Rescuers taking survivors to a place of safety ashore should provide as much of this support as possible, and should also seek any information that may assist in the ongoing MRO. We will discuss each of the main subject areas in turn below.

2.6 Some rescue units may find it difficult to provide this support, when the ratio of crew to the number of survivors is low, for example, and/or when the transfer to the place of safety ashore will take some time. The SAR Mission Coordinator (SMC) is responsible for ensuring that the necessary support is provided, transferring external support to the rescue unit if necessary (and if possible). The SMC should not assume that, just because survivors are aboard a rescue unit, the job is done. Rescue is a holistic process, and the SMC is responsible for coordinating the whole of it. Similarly, the commanders of rescue units are responsible for asking for help if they need it. See chapters 19 & 22.

3 Safety and shelter

3.1 A ‘place of safety’ is one where people are safe, even if they do not feel themselves to be so. Non-mariners being rescued from a shipping accident, for example, may not feel really safe again until they are back on dry land. But taking them there may take time if the landing site is a distance away or the
A rescue unit has more work to do on scene. It follows that survivors should be kept as fully informed as possible about what their rescuers intend. In general, people will be better able to control themselves, and to do what is asked of them, if they can see that what is being done is for their own good or for the immediate good of others. We discuss this further below.

3.2 Once aboard the rescue unit survivors should be escorted to a safe place and kept there, with any instructions necessary to their continuing safety clearly explained to them.

3.3 They should be protected from outside interference. This includes news media interest, which may make itself felt while the rescue unit is still transferring people to the final place of safety and/or at the landing site. Advice on contact with the news media is included in IAMSAR Volume III, and in chapter 7.

3.4 Survivors may also be at some risk from each other. Passengers may want to blame crew members for the accident, for example; or the distress of some (over a missing family member, perhaps) may be too much for others to bear. If practicable, the place of safety should be so arranged that those needing privacy can obtain it.

3.5 In many cases a rescue unit will have few crew available to provide general care. (We discuss medical care and other important requirements such as information-gathering below.) The next best resource on most units will be the other survivors, who can be asked to assist in various ways. Giving people things to do is beneficial to themselves as well as for those they care for and the busy rescue unit crew.

3.6 If the rescue unit is itself a passenger vessel it is best to prevent that ship’s passengers from mingling freely with the survivors, if the vessel’s design permits separation. Uncontrolled mixing will make it difficult for the rescue unit’s crew to determine who is being rescued and who is part of their own passenger complement; and it may not be welcomed by the survivors themselves. However, there are likely to be people with useful medical or other care skills among the rescuing vessel’s passengers. They should be asked to identify themselves and can be used accordingly.

3.7 Survivors should be sheltered from the elements, if possible, during transfer. Ideally the ‘temporary place of safety’ aboard the rescue unit should be dry, out of the wind and sun, and protected from too much cold or heat. In a cold climate people need to be kept warm enough to prevent the onset of hypothermia. Remember that survivors will be sitting or lying still; they may be wet, injured, seasick, frightened, elderly, very young, etc, and in most cases they will not be wearing protective clothing. They will therefore be prone to hypothermia.

3.8 On some rescue units the ideal conditions of shelter will not be achievable: people may have to be transferred on open decks, for example. If so, the rescue unit’s crew must monitor them closely – with the assistance of the more able survivors – and transfer the worst cases to a more sheltered position. Medical evacuation by more suitable units may also be an option.

4 Medical needs: triage and first aid

4.1 There are two broad categories of medical need in these circumstances: the injuries and conditions that people have acquired as a result of the incident itself, and pre-existing requirements for care and/or medication. The latter are less likely to be of immediate concern aboard a rescue unit: they will be

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2 Concern has sometimes been expressed that volunteer helpers may not have the skills they claim, and that allowing them access to survivors adds an avoidable risk. This may be so – but the exigencies of the case may require that risk to be taken. Leaving survivors unattended constitutes a greater risk.
addressed at the ‘final’ place of safety (see chapter 11). Some injuries or medical conditions, however, may need more urgent attention. In most cases this will take the form of whatever first aid treatment can be managed during the transfer. With many people to be assessed, treatment priorities need to be established. This is done by triage.

4.2 Triage is the process of determining the priority in which injured or sick people should be treated and transported, based on the severity of their condition. It is used when there are too many people to treat at once: someone has to wait. In emergencies people are usually triaged several times, with the analysis becoming progressively more sophisticated at each stage. In the early stages, people who are judged unlikely to survive will not be the first priority; nor will people whose handling will be so difficult that it will take longer to retrieve them than it would to recover more able people. A helicopter capable of taking 15 ‘walking wounded’ may only be able to manage two stretcher cases, for example. If the 15 will not survive until another unit can rescue them, they will be the priority. Later, with more, and more sophisticated, medical and transport resources available, the priorities are likely to change.

4.3 Many different triage systems are in use around the world, but casualties are often classified into four categories, as follows:

- Priority I: Immediate care
- Priority II: Delayed care
- Priority III: Minor care
- Priority IV: Deceased.

4.4 Ideally, triage should have begun aboard the unit in distress, although this may have been little more than distinguishing between those who can and cannot help themselves, depending on the rapidity of the evacuation – see chapter 8. A more thorough review should take place aboard the rescuing unit while survivors are being transferred to the ‘final’ place of safety.

4.5 The form the triage process takes during transfer to the final place of safety will depend on the medical expertise immediately available. Designated SAR units should, ideally, have medically trained personnel aboard, either as part of their usual crews or by prior arrangement. Other rescue facilities (vessels of opportunity, for example) may have limited medical capability. They should be supported during the transfer.

4.6 The support provided will depend on the need identified during triage. If the rescue unit does not have sufficient medical expertise on board, the Rescue Coordination Centre (RCC) should be notified. In some circumstances, when survivors may have to remain aboard the rescue unit for some time, it may be practicable to transfer the most urgent cases to a faster means of transport – a helicopter, for example – or to place medical teams aboard the rescue unit to assist. Medical advice can be arranged by the RCC, preferably using an established Telemedical Assistance Service (TMAS). See IAMSAR Volume II Chapters 1.4 and 6.6, and Appendix R; and Volume III Section 3.

4.7 In any event the RCC must be told as early as possible the number of people each rescue unit has aboard, the number who require treatment, a summary of their condition and their current priority status, and the number of any confirmed dead, so that the receiving authorities ashore can be notified and prepared.

3 However, if there is a choice of rescue units available, helicopters may be better used for cases whose transfer into boats etc would be difficult and delay the rescue of others. See chapter 23.
Triage is therefore a primary function aboard rescue units. The information sent to the RCC should be updated and amended as necessary as the transfer proceeds.

4.8 As noted above, the survivors themselves or people in a rescuing vessel’s passenger complement may be able to assist by monitoring the injured or unwell or by providing first aid or more sophisticated medical care during rescue.

4.9 Triage systems in use around the world differ in detail. It is not the purpose of this guidance to recommend particular systems – but it is recommended that, where practicable, a common system should be adopted locally by the response organisations planning for MROs together. This means that the system will work for the survivor wherever s/he is in the rescue system and will help to ensure that information gathered early in the response is not lost. The latter point is particularly important for survivors given medical attention during rescue, when a full history is very helpful to subsequent carers. The triage system selected should enable record-keeping as well as rapid identification of priorities. There are various triage cards available, for example, which use colours to indicate a person’s current condition at a glance but which also allow for additional information to be written in. The card travels through the rescue process with the survivor.

4.10 Except for designated SAR units, ferry companies and the offshore industry, those involved at the beginning of the rescue operation may not be able to participate in the common triage and recording system recommended above. MRO planners should encourage its adoption where possible, and arrange for it to be introduced at as early a stage as practicable in all mass rescue responses.

4.11 IAMSAR Volume II Chapter 6.17 supports this recommendation, noting that

“casualty identification tags should be standardized through priority numbering and colour coding to make them suitable in multilingual situations. The following coding is widely used:

- Priority I / immediate: a red tag or card, with Roman numeral I
- Priority II / delayed: a yellow tag or card, with Roman numeral II
- Priority III / minor: a green tag or card, with Roman numeral III
- Priority IV / deceased: a black tag or card, with Roman numeral IV.

“Tags or cards should be usable under adverse weather conditions, and be water resistant. Coloured light sticks or reflectors are also useful. A card can be used to supply basic information about the casualty, if time permits: identification details, injuries observed, treatment given, etc. If tags or cards are not available, prioritization can be indicated by marking the appropriate Roman numeral on adhesive tape, the casualty’s clothing or exposed skin.”

4.12 For further discussion of prioritisation in rescue, see chapter 8. For on-board support, see chapter 15. For further discussion of medical support at the place of safety, see chapter 11. IAMSAR Volume III, Section 20, provides guidance on what medical information should be recorded. IAMSAR Volume II Chapter 6.17 discusses the care of survivors, including triage.

5 Welfare support

5.1 Triage – prioritising the survivors’ medical needs – and first aid are fundamental functions during rescue, but are not the only aid that can and should be given to survivors. Food and, especially, drink should be provided if possible (unless medical advice is against it in particular cases). If survivors are likely to be aboard the rescue unit for some time, supplies might have to be brought in: large ships may have small crews and on-board stocks can be quickly depleted if many survivors are being carried. As noted above,
it is the SMC’s responsibility to ensure that contact is maintained with the rescue units, and additional help provided as necessary and practicable.

5.2 Survivors’ sanitary needs should be catered for so far as possible, with access to toilets and basic washing facilities. People may be sea- or airsick during transfer, and if this can be catered for the trip will be less difficult for everyone.

5.3 The more that can be done to comfort and reassure survivors during the transfer, the better for all concerned. Survivors are likely to have been more or less traumatised by their experience. They may be injured or unwell, cold and wet. They may be deeply concerned about missing family members or friends. The transfer process itself may be frightening.

5.4 In most cases the rescue unit’s crew and any helpers they have been able to identify will be able to do relatively little about these concerns, apart from offering general reassurance. People can be assured that they are being taken to safety, for example, or that SAR action is continuing. Warm drinks will be beneficial, as will blankets etc. Humanitarian care at its simplest level will achieve a great deal.

5.5 Human nature inevitably plays its part in such circumstances. Some survivors will be demanding, possibly about relatively trivial matters. Others will not want to trouble their busy rescuers, even though they may have urgent needs. Rescuers should try to assess survivors’ needs objectively, and be firm as well as compassionate.

6 Communications

6.1 It is sometimes forgotten – understandably so in the stress of an MRO – that survivors are people with information and communication needs as well as physical ones. While it can be argued that these are secondary concerns during the rescue phase, particularly in rescue units with limited crew available to look after the survivors, they should not be overlooked – and rescuers’ work will be made easier if they can be addressed.

6.2 Survivor communications can be considered in three categories: providing information to survivors; acquiring information from survivors; and providing communications facilities for survivors to use for their own purposes – principally contacting their family and friends to assure them of their survival. This last may be impracticable in most cases during rescue – but is less so if survivors will be in the ‘temporary place of safety’ for some time, or are being kept aboard their parent vessel: see chapter 15. Acquiring information from survivors is discussed below. But what can be overlooked, unnecessarily, during rescue is the provision of information to those being rescued.

6.3 It is useful to consider what we ourselves would do if we were in the survivors’ circumstances. We would doubtless understand that people are busy trying to help us and that they are, presumably, following some sort of plan. If we think about it, we will also understand that individual rescuers are unlikely to have the answers to all the questions we would like answered. But we would be happier if we were told at least something about what is going on and what is to be done with us – and happier survivors are easier to manage.

6.4 It follows that it is in rescuers’ as well as survivors’ interests to keep the latter informed. All the SAR facilities involved on scene should have at least an overview of the MRO plan, provided they are in communication with the Rescue Coordination Centre, On Scene Coordinator or Aircraft Coordinator, and they will know their own tasking. Not everything can or should be relayed to survivors aboard – but
rescuers should provide the information most likely to be needed: where are we going? When will we get there? Is more help coming? What about missing people? And so on.

6.5 The provision of information should be managed, to ensure that all survivors are told the same thing; it should be factual; and speculation should be avoided. If rescuers do not know the answers to survivors’ questions, they should say so, and that more information will be available at the final place of safety – which, eventually, it will be.

6.6 A common language is, of course, essential to full communication – and individual survivors may not have a language in common with their rescuers or their helpers. But humans have remarkable facility in face-to-face communication and basic information can usually be conveyed by sign language and other visual aids (charts, clocks etc): it is worth the effort. Rescuers should remember, however, that, even though they may have a language in common, survivors may not understand their professional jargon. The key is to keep it simple – but do communicate!

7 Accounting for people

7.1 Information is needed from, as well as by, the survivors. Acquiring other information is discussed below, but the primary information requirement is to account for everyone involved in the incident. This means accurately counting everyone in each rescue unit, and gathering information about people believed to be missing: see chapter 9.

7.2 Although their physical or psychological condition may prevent it, survivors are very likely to express concern for missing friends or family members to their rescuers during the transfer phase. This information is of vital importance to the MRO coordinators and should be passed to the RCC without delay. In confused conditions aboard a crowded rescue unit it may be that people have, in fact, only been temporarily separated – but resolving these issues can take time, and the RCC should be informed at once of any reports of missing persons.

7.3 If the transfer process will take some time, rescue unit crews may be asked to try to find objects on unconscious survivors or the dead that will assist in identifying them. All personal belongings must remain with their owners during the transfer, however, to avoid confusion later.

8 Information from survivors

8.1 Survivors will hold information of great importance to subsequent investigations of the incident. In principle, this should be collected by professional investigators at the final place of safety or later. Nevertheless, people may want to talk about their experience during their rescue, and if the resource is available to collect it ‘passively’ – that is, without asking leading questions which may confuse the survivor and damage their later testimony – this should be done.

8.2 Of more immediate importance to the ongoing SAR operation, however, will be any information survivors may have concerning others’ safety. Did they see people still aboard the casualty vessel, for example, or drifting away in the confusion?

8.3 IAMSAR Volume III section 20 gives examples of questions that can be asked, but notes that:

"Care must be taken to avoid worsening a survivor’s condition by excessive interrogation. If the survivor is frightened or excited, the questioner should assess [their] statements carefully.
Questions should be asked in a calm voice and the questioner should avoid suggesting answers to the survivor. Explain that the information required is for the success of the SAR operation.”

9 Summary

- Survivors should be supported as best possible during the transfer phase, between retrieval and landing at the final place of safety.
- A ‘temporary place of safety’ must, of course, be safe, and should be sheltered from the elements so far as possible.
- Counting and medical triage are primary functions after retrieval. The results should be passed to the Rescue Coordination Centre without delay.
- A common triage system should be agreed locally by as many responders as possible.
- Medical advice and assistance may be sought via the RCC.
- Survivors’ basic welfare needs should be catered for during the transfer phase if possible, with assistance sought via the RCC as necessary.
- Rescue units’ crews can be assisted in their first aid and survivor support work by other survivors and – if the rescue unit is a passenger vessel – suitable volunteers from the passenger complement.
- Survivors will be easier to manage if they understand what is happening. Keeping them properly and clearly informed will be of benefit to all involved.
- Survivors are a valuable source of information, particularly as regards accounting for everyone involved in the incident; but any questioning needs to be handled carefully and the responses objectively assessed.

10 Further reading

10.1 Further advice on the care and questioning of survivors, and what to do with the deceased, is in the IAMSAR Manual Volume II Chapter 6.17, 6.18 & 6.19, and in Volume III Sections 20 and 21.

10.2 For medical care, advice and assistance, see IAMSAR Volume II Chapters 1.4 and 6.6, and Appendix R; and Volume III Section 3. IAMSAR Volume III also contains useful guidance for rescue unit crews on contact with the news media, in Section 22.

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